

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2011

FORM APPROVED

OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155673 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____              |  | (X3) DATE SURVEY<br>COMPLETED<br>07/07/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>MARKLE HEALTH & REHABILITATION |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>170 N TRACY ST<br>MARKLE, IN46770 |  |   |                            |
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| K0000  | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/07/11</p> <p>Facility Number: 000544<br/>Provider Number: 155673<br/>AIM Number: 100267340</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Markle Health and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully</p> |   |  | K0000  |  |   |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K0014<br>SS=F  | sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and all resident rooms on the 300 hall. The facility has a capacity of 100 and had a census of 67 at the time of this survey.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/13/11.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: |   |  |  |   |   |                            |
|  | Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2<br><br>Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within exit access for 4 of 4 corridors in the facility. This deficient practice      |   |  | K0014  | K 0014It is the practice of this facility to obtain documentation for the flame spread rating of interior materials installed within exit access.I. Corrective Action TakenFacility has a copy of the flame spread rating for the carpet that was installed on the bottom third of the corridor walls |   | 08/06/2011                 |

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| K0044<br>SS=E  | could affect all occupants.<br><br>Findings include:<br><br>Based on observations with the Environmental Supervisor on 07/07/11 during the tour from 11:53 a.m. to 2:10 p.m., carpet was installed on the bottom third of the corridor walls throughout the facility. Interview with the Environmental Supervisor at the time of observation, revealed no documentation was available to demonstrate the carpet provides a flame spread rating of Class A or Class B.<br><br>3.1-19(b) |   |  | K0044  | throughout the facility.II. Identification of Other ResidentsAll residents have the potential to be affected by this alleged deficient practice.III. Measures Put In PlaceIn the future, prior to the installation of new carpet, the facility will require the vendor to provide documentation of the flame spread rating. Maintenance will keep copies of the documents in a binder.IV. Monitoring of Corrective ActionSafety Committee will monitor compliance by reviewing the documents in the Flame Spread Binder once per quarter. |   | 08/06/2011                 |
|  | Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5<br>1. Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In  |   |  |  | K 0044It is the practice of this facility to ensure all fire doors close and latch properly.I. Corrective Action Taken 1. The door on 200 hall was adjusted and now closes and latches properly. 2. The service door between the kitchen and main dining room will be replaced by 8-6-11.II. Identification of Other Residents 1. All residents have the potential to be affected   |   |                            |

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|  | <p>addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any residents at the main nurses' station and twenty eight residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/07/11 at 12:35 p.m., the fire doors entering the 200 hall from the main nurses' station failed to latch into the frame. Based on an interview with the Environmental Supervisor at the time of observation, these doors were confirmed to be fire doors.</p> <p>3.1-19(b)</p> <p>2. Based on observations and interview, the facility failed to ensure 1 of 2 single fire barrier doors was provided with the appropriate fire protection rating for the location in which they are</p> |   |  |  | <p>by this alleged deficient practice. 2. All residents who go to the dining room have the potential to be affected by this alleged deficient practice.III. Measures Put In Place 1. Maintenance personnel will check all fire doors for proper closure one x weekly x 90 days and document findings. Any identified issues will be immediately corrected. 2. A new door has been ordered and will be installed by 8-6-11. Door has the required 1 1/2 hour fire rating.IV. Monitoring of Corrective Action 1. Maintenance will report any non-compliance immediately to facility ED/DNS &amp; to the monthly Safety Committee. 2. Maintenance will monitor for presence of the fire-rating tag on the dining room service door each month during walking rounds. Maintenance will document compliance on a monthly CQI tool &amp; present to the Safety Committee for review and recommendations.</p> |   |                            |

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|  | <p>installed. LSC 7.2.4 leads to LSC 7.2.4.3.4 which requires openings in fire barriers comply with LSC 8.2.3.2.3.1 which requires 1 1/2 hour doors in 2 hour fire barriers. This deficient practice could affect any residents in the main dining room.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/07/11 at 1:05 p.m., the service door between the kitchen and main dining room was a nonrated metal door. Based on an interview with the Environmental Supervisor at the time of observation, the door is in a two hour fire wall. Additionally, the door beside the service door entering the kitchen in the same two hour fire wall was a one and one half hour fire rated door.</p> <p>3.1-19(b)</p> |   |  |  |  |   |                            |
| K0046<br>SS=F  | Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.  |   |  |  |  |   |                            |

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|  | <p>Based on observation and interview, the facility failed to ensure 2 of 2 emergency light fixtures of at least 1½ hour duration were tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with Environmental Supervisor on 07/07/11 at 1:15 p.m. and 1:20 p.m., a battery operated emergency light was observed at</p> |  |  | K0046  | <p>K046It is the practice of this facility to ensure the periodic testing of emergency lighting is performed at 30 day intervals for a minimum of 30 seconds and to ensure an annual test is conducted on every battery powered emergency lighting system for no less than 1 1/2 hour duration.I. Corrective Action TakenEmergency lighting was tested for a minimum of 30 seconds.An annual test was conducted on every battery powered emergency lighting system.II. Identification of Other ResidentsResidents do not have the potential to be affected by this alleged deficient practice.Maintenance has been re-instructed on the requirements of conducting Periodic Testing of Emergency Lighting Equipment.III. Measures Put In PlaceMaintenance has re-implemented a monthly monitoring sheet entitled "Battery-Operated Emergency Lights-Test Log". Log will be completed each month.IV. Monitoring of Corrective ActionED/designee will monitor compliance by reviewing this log each month. ED/designee will initial and date the log upon review. Any issues will be reported to the Safety Committee for review and recommendations.</p> |  | 08/06/2011                 |

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| K0048<br>SS=F  | the kitchen exit door and a battery<br>powered emergency task light was<br>observed at the generator. Based<br>on an interview with the<br>Environmental Supervisor on<br>07/07/11 at 11:18 a.m., there<br>were no written records of<br>monthly tests, or an annual test,<br>for the battery operated<br>emergency lights available for<br>review.<br><br>3.1-19(b)   |   |  |  |  |   |                            |
|  | There is a written plan for the protection of all<br>patients and for their evacuation in the event<br>of an emergency. 19.7.1.1<br>Based on record review and interview,<br>the facility failed to include the<br>evacuation of the smoke<br>compartment in the written fire plan<br>for the protection of 67 of 67<br>residents in the event of an<br>emergency. LSC 19.7.2.2 requires a<br>written health care occupancy fire<br>safety plan that shall provide for the<br>following:<br>(1) Use of alarms<br>(2) Transmission of alarm to the fire<br>department |   |  | K0048  | K0048It is the practice of this<br>facility to ensure there is a written<br>plan for the protection of all<br>patients and for their evacuation<br>in the event of an emergency.I.<br>Corrective ActionFacility has a<br>written plan which addresses the<br>evacuation of the smoke<br>compartment.II. Identification of<br>Other ResidentsAll residents<br>have the potential to be affected<br>by this alleged deficient practice.<br>Staff will be inserviced on the<br>update to the emergency plan by<br>8/6/11. Inservice will be |   | 08/06/2011                 |

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|  | (3) Response to alarms<br>(4) Isolation of fire<br>(5) Evacuation of immediate area<br>(6) Evacuation of smoke compartment<br>(7) Preparation of floors and building<br>for evacuation<br>(8) Extinguishment of fire<br>This deficient practice could affect all<br>occupants.<br><br>Findings include:<br><br>Based on a review of the<br>Fire/Disaster/Safety Plan with<br>Environmental Director on 07/07/11<br>at 11:50 a.m., the fire plan did not<br>address the evacuation of the smoke<br>compartment. This was<br>acknowledged by the Environmental<br>Director at the time of record<br>review.<br><br>3.1-19(b) |   |  |  | performed by the Maintenance<br>Director/designee.III. Measures<br>Put In PlaceFacility<br>Fire/Disaster/Safety Plan has<br>been updated to address the<br>evacuation of the smoke<br>compartment. IV. Monitoring of<br>Corrective Action TakenCQI<br>Committee will periodically review<br>our Fire/Disaster/Safety Plan for<br>updates. |   |                            |

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| K0051<br>SS=D  | <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the 300 hall shower room was installed where air flow would not adversely affect its operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect any residents in the 300 hall shower room.</p> |  |  | K0051  | <p>K0051 It is the practice of this facility to ensure all smoke detectors are installed where air flow does not adversely affect the operation of the detectors.I. Corrective Action TakenThe smoke detector is positioned where the air flow does not adversely affect the operation of the detector.II. Identification of Other ResidentsAll residents who use the 300 hall shower room have the potential to be affected by this alleged deficient practice. All smoke detectors in the facility were checked for proper placement on 7-19-11. No other detectors were found to be improperly placed.III. Measures Put in PlaceThe smoke detector was relocated on 7-19-11.IV. Monitoring of Corrective Action</p> |  | 08/06/2011                 |

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| K0062<br>SS=D  | Findings include:<br><br>Based on an observation with the Environmental Supervisor on 07/07/11 at 12:01 p.m., the smoke detector in the 300 hall shower room was located within three feet of a air supply duct. This was acknowledged by the Environmental Supervisor at the time of observation.<br><br>3.1-19(b)   |   |  | K0062  | TakenMaintenance will monitor monthly during facility rounds and report non-compliance during the monthly Safety Committee meeting.   |   | 08/06/2011                 |
|  | Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>1. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads was unobstructed in the Social Service office. LSC 9.7.5 requires all automatic sprinkler systems be inspected and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states |   |  |  | K0062It is the practice of this facility to ensure automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.I. Corrective Action<br>1. Sprinkler head in Social Services office is now unobstructed. 2. There is no trace of paint on the sprinkler head in the laundry room.II. Identification of Other Residents 1. Residents who frequent the Social Services Office could be affected by this alleged deficient practice. 2. |   |                            |

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|  | <p>unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any residents in the Social Service office.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/07/11 at 12:51 p.m., the spray pattern of the sprinkler head in the Social Service office was obstructed by a ceiling light fixture on both sides of the sprinkler head. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 1 sprinklers in the ceiling which had been painted in the laundry room behind the dryers. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of</p> |  |  |  | <p>No residents are affected by this alleged deficient practice. III. Measures Put in Place 1. Sprinkler head will be lowered by 8/6/11. 2. Sprinkler head will be replaced by 8/6/11.IV. Monitoring of Corrective Action 1 &amp; 2. Maintenance will monitor for the presence of paint on sprinkler heads immediately after any area in the facility has been re-painted. All non-compliance will be promptly corrected and reported to the facility ED/designee for follow-up.</p> |  |                            |

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| K0064<br>SS=D  | <p>Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/07/11 at 1:15 p.m., there was paint on the deflector of the ceiling sprinkler head behind the dryers. This was acknowledged by the Environmental Supervisor at the time of the observation.</p> <p>3.1-19(b)</p> |   |  |  |  |   |                            |
|  | <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 3 of 3 fire extinguishers in the kitchen and 1 of 1 laundry</p>   |   |  | K0064  | <p>K064It is the practice of this facility to inspect fire extinguishers at least monthly with the date of the inspection and the initials of the person</p> |   | 08/06/2011                 |

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|  | <p>room fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any number of kitchen and laundry staff.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 07/07/11 from 1:13 p.m. to 1:17 p.m., the monthly inspection tag for the laundry fire extinguisher lacked documentation of a monthly inspection since April</p> |  |  |  | <p>performing the inspection recorded.I. Corrective Action TakenThe fire extinguishers in the kitchen have been inspected.The fire extinguisher in the laundry has been inspected.II. Identification of Other ResidentsMaintenance director has been instructed on the responsibility of inspecting fire extinguishers each month. Instruction was completed by 8-6-11.III. Measures Put in PlaceMaintenance performs an inspection of all fire exguishers on a monthly basis. All extinguishers will be inspected prior to the Monthly Safety Committee Meeting. IV. Monitoring of Corrective Action Monitoring will be done by completion of a monthly CQI tool. Maintenance will complete the tool and report compliance during the monthly Safety Committee meeting.</p> |  |                            |

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| K0067<br>SS=E  | <p>2011, and the monthly inspection tags for the three fire extinguishers in the kitchen lacked documentation of a monthly inspection for the month of June, 2011. This was acknowledged by the Environmental Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 dampers in the ventilation system was inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all</p> |   |  | K0067  | <p>F067It is the practice of this facility to ensure the heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications.I. Corrective Action TakenThe fire damper at the 300 hall fire barrier wall was inspected on 7/24/11.II. Identification of Other ResidentsAll residents on 300 hall have the potential to be affected by this alleged deficient practice. Maintenance has been instructed on the requirements to perform an inspection of the dampers. Instruction was completed by 8/2/11.III. Measures Put In PlaceMaintenance will complete the "Fire/Smoke Damper Maintenance Record" upon</p> |   | 08/06/2011                 |

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|  | <p>dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all twenty residents on 300 hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/07/11 at 2:05 p.m., there was a fire damper in the ventilation system at the fire barrier wall of the 300 hall. Based on interview with the Environmental Supervisor on 07/07/11 at 2:30 p.m., he was not aware of the damper and was unable to provide documentation to show the damper had been inspected.</p> <p>3.1-19(b)</p> |   |  |  | <p>testing of the fire dampers.IV. Monitoring of Corrective Action ED/designee will monitor by initialing the "Fire/Smoke Damper Maintenance Record" when completed.</p> |   |                            |

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| K0074<br>SS=F  | <p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 49 of 49 resident rooms were flame retardant. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 07/07/11 from 11:53 a.m. to 2:10 p.m., the window coverings in all of the resident rooms lacked attached documentation confirming they were inherently flame retardant. Based on interview with the Environmental Supervisor at 12:40 p.m.,</p> |  |  | K0074  | <p>K074It is the practice of this facility to ensure draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the installation of Sprinkler Systems.I. Corrective Action TakenFacility has obtained documentation concerning the flame spread rating of the curtains in resident rooms.II. Identification of Other ResidentsAll resident rooms have the potential to be affected by this alleged deficient practice. Maintenance has been instructed to obtain a copy of the flame spread rating when purchasing curtains or other fabric items. Instruction took place by</p> |  | 08/06/2011                 |

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| K0076<br>SS=E  | <p>documentation regarding the flame retardancy for these window coverings was not available for review.</p> <p>3.1-19(b)</p>   |   |  | K0076  | <p>8/2/11.III. Measures Put in PlaceIn the future, prior to purchasing new curtains, the facility will require the vendor to provide documentation of the flame spread rating. Maintenance will keep copies of the documents in a binder.IV. Monitoring of Corrective ActionSafety Committee will monitor compliance by reviewing the documents in the Flame Spread Binder each quarter.</p>  |   | 08/06/2011                 |
|  | <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure combustible materials were separated from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, the Standard for Health Care Facilities, Section 8-3.1.11.2(c)2 requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet in a fully sprinklered building. This deficient practice affects residents</p> |   |  |  | <p>F076It is the practice of this facility to ensure medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.I. Corrective Action TakenThe combustible materials were removed from the Oxygen storage area.II. Identification of Other ResidentsResidents affected by this alleged deficient practice are those at the nurses station.All staff will be inserviced about not storing combustible materials in the Oxygen Storage area. Inservice will be completed on 8/6/11.III. Measures Put In</p> |   |                            |

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| K0130<br>SS=E  | <p>at the main nurses' station.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/07/11 at 11:58 a.m., combustible material such as cardboard boxes and plastic items were stored within three feet of stationary liquid oxygen containers in the oxygen storage room. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> |  |  |  | <p>PlaceMaintenance will check the Oxygen Storage Area each week x 3 months. Checks will be documented on a CQI tool and provided to the ED/designee.IV. Monitoring of Corrective Action Results will be presented to Safety Committee Meeting each month for follow up and recommendations.</p>  |  |                            |
|  | <p>Based on observation and interview, the facility failed to ensure 4 of 14 penetrations of the fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC</p>                         |  |  | K0130  | <p>K130It is the practice of this facility to ensure penetrations of the fire barrier walls are protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier.I. Corrective Action Takena) the area in the drop down ceiling at the 100 hall fire wall has been repaired by using a fire resistant material.b) the area in the 300 hall attic fire barrier around the telephone line has been repaired by using a fire resistant material.c) the area in the Augusta's Cottage attic fire</p> |  | 08/06/2011                 |

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|  | <p>8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect four of five smoke compartments.</p> |  |  |  | <p>barrier wall around an internet wire has been repaired by using a fire resistant material.d) the area in the service hall attic fire wall around the main sprinkler line has been repaired by using a fire resistant material.II.</p> <p>Identification of Other Residents</p> <p>All residents have the potential to be affected by this alleged deficient practice. Maintenance was educated about preventing penetrations of the fire barrier walls. Education was completed by 8/6/11.III. Measures Put In PlaceAfter the facility has any type of work performed by contractors, maintenance will promptly inspect the fire walls in the attic and above the drop ceiling for the presence of any unsealed penetrations. Inspection by maintenance will be performed within 7 days of contractor's completion of job.IV.</p> <p>Monitoring of Corrective ActionResults of Maintenance Inspections will be reported to the monthly Safety Committee Meeting for review and recommendations.</p> |  |                            |

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|  | Findings include:<br><br>Based on observations with the Environmental Supervisor on 07/07/11 from 1:50 p.m. and 2:10 p.m., the following fire walls had unsealed penetrations:<br>a) above the drop down ceiling at the 100 hall fire wall there was one of seven penetrations measuring three fourths inch around the main sprinkler line.<br>b) in the 300 hall attic fire barrier one of four penetrations measuring one inch around the telephone line<br>c) in the Augusta Cottage attic fire barrier wall one of one penetration measuring two inches around a Internet wire<br>d) in the service hall attic fire wall one of two penetrations measuring two inches around the main sprinkler line.<br>Based on an interview with the Environmental Supervisor at the time of observations, the walls were fire barrier walls.<br><br>3.1-19(b) |   |  |  |  |   |                            |
| K0147<br>SS=E  | Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  |   |  |  |  |   |                            |

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|  | <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/07/11 at 1:10 p.m., an extension cord was plugged in and providing power for a microwave in the employee's lounge. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> |   |  | K0147  | <p>K147It is the practice of this facility to ensure electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2.I. Corrective Action TakenThe extension cord was removed from the employee break room.II. Identification of Other ResidentsNo residents were affected by this alleged deficient practice.Staff was inserviced about extension cords.Inservice was completed by 8/6/11.III. Measures Put In PlaceMaintenance will check for the presence of extension cords weekly x 3 months. Rounds will be documented on a CQI form.IV. Monitoring of Corrective Action Results will be reported to the monthly Safety Committee for review and recommendations.</p> |   | 08/06/2011                 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2011

FORM APPROVED

OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155673 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____               |  | X3) DATE SURVEY<br>COMPLETED<br>07/07/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>MARKLE HEALTH & REHABILITATION |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>170 N TRACY ST<br>MARKLE, IN46770 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |  |  |  |                            |